
**Rhode Island Health Care Quality
Performance Measurement and Reporting Program**

**Health Care Quality Steering Committee Minutes
September 12, 2005**

Present: T Almon, A Frazzano, L Holland, B Waters, H Zuffoletti, P McCue, L McDonald, F Robbins, M Sayles, A Santos, A Tavares, C Duquette, J Buechner, S Oberbeck

Guests: F Donahue, D Collins, J Lowell, M Brunell, S Sawyer, S Brasil, C Lamoureux, G Levesque, K Shatraw, J McLaughlin, J McLaughlin, D Huntley-Newby, D Joseph, M Javanmardian, H Constantine, R Rusin, M Doherty, P McBride, M Richards, K Gurbe, B Koconis, B Isaiah, B Novak

Dr. Waters welcomed the attendees.

Sue Oberbeck announced that Health Care Quality Steering Committee materials will no longer be mailed, but will be emailed. This includes the agenda, the minutes, and relevant materials. Up-to date email addresses are requested. The Health Care Quality Steering Committee agenda and minutes are also posted on the Secretary of State's website <http://www.sec.state.ri.us/pubinfo/openmeetings>. All of the Health Care Quality Performance Measurement and Reporting Program committee and subcommittee meetings are posted on the Calendar of Events on HEALTH's website <http://www.health.ri.gov/calendar.php>. Those without email access will continue to receive mailings. If you have any questions, please contact Sue at SusanO@doh.state.ri.us, or at soberbeck@cox.net.

Dr. Dwight McNeill of the Agency for Healthcare Research and Quality (AHRQ) presented, "Healthcare Quality in the State of Rhode Island: From the lens of the National Healthcare Quality Report." The information was based on the 2004 National Health Care Quality and Disparities Report.

Overall, quality is improving at a median rate of annual improvement of 2.8%. 10 measures improve for every one that declines. There is significantly higher improvement for patient safety, CMS' measures for heart and pneumonia, as well as other diseases and settings. Many measures are changing slowly, or not at all. Disparities continue, but there is improvement.

To view the Rhode Island report, the website is: www.ahrq.qualitytools.ahrq.gov/qualityreport/state. There are a total of 85 measures from 10 databases. Rhode Island was above average in 30 measures. Two examples of where Rhode Island does well are: percent of women age 40 and over who report they had a mammogram within the past 2 years, and

percent of women receiving prenatal care in the first 3 months of pregnancy. The 85 measures include effectiveness of care, nursing home health, timeliness of treatment, and patient centeredness. AHRQ has consolidated measures, providing comparisons and benchmarks, trending the data, and summarizing the data into a "dashboard."

On the overall healthcare quality index (a ratio of number of measures above average to the number below average), the national median was slightly less than 1.0. Other than Rhode Island, the New England states ranged from 1.4 to 2.0. Rhode Island's overall rating surpassed these at 3.0.

Dr. McNeill presented a proposed Rhode Island Healthcare Quality Dashboard. The data included in a visual format reports the overall healthcare quality index, color coded meters for: major illness (cancer, diabetes, heart disease, and respiratory), dimensions of care (staying healthy, getting better, living with illness), and setting of care (hospital, home health, nursing home, and ambulatory). "Warning lights" and "Kudos" were also included.

For Rhode Island, the warning lights were: pressure ulcers in nursing homes, pediatric asthma, and congestive heart failure. The kudos were: cancer screening, maternal and child health, and home health.

The dimensions of care meter was compared to neighboring states. Rhode Island was relatively the same with regard to staying healthy (primary prevention), doing very well at getting better (heart disease and pneumonia), and okay with living with illness (diabetes and other chronic illnesses).

The major illness meter looked at cancer (death rate), diabetes (hemoglobin A1-C, and follow-up for eye and foot exams), heart disease and respiratory (pneumonia). The other New England states rated better in diabetes and heart disease.

In the setting of care meter, Rhode Island performed very well in hospitals and home health, compared to the neighboring states. Rhode Island was "AOK" in nursing homes, but did less well in ambulatory settings. Rhode Island did not do as well with diabetes, heart disease and prevention as the other New England states.

In "Rhode Island Improvement Opportunities", six areas were identified where Rhode Island performed below average nationally, and in comparison to the neighboring states: admissions for congestive heart failure per 100,000 adult population, admissions for pediatric asthma per 100,000 population under age 18, percent of long-stay nursing home residents

with a urinary tract infection, percent of long-stay nursing home residents who have pressure sores but are at low risk (i.e., are active and adequately nourished), and percent of short-stay nursing home residents with pressure sores. (The nursing home data is based on 2003 data.)

Dr. McNeill noted that with regard to improving care, it has been stated that if we only did what we know, we would make improvements. He noted some caveats and questions regarding the dashboard: aggregating measures is tricky, and neighboring states may not be the best comparison. He is interested in what are the most important measures for state leadership, whether there is interest in this information going forward, how helpful it is for informing policy and practice, and the overall reaction to "warning lights."

The question was raised, "How, in this economic model, are we going to improve quality?" The suggestion was via collaborations such as the Health Care Quality Steering Committee, learning networks such as the work Don Berwick is doing at the Institute for Healthcare Improvement, discounting competitive healthcare, and having payers and states inform the public and push for quality. Another question was raised about whether the competitive model has worked at all. It was acknowledged that this is more difficult when money is involved.

Dr. McNeill noted that states have noted there are too many measures which prompted the development of the dashboard. 2004 data will be available in November or December. He wondered if there was interest in receiving the dashboard again. Dr. McNeill invited feedback at: dmcneill@ahrq.gov.

Dr. Minoo Javanmardian presented, "Help Wanted: The Growing Crisis in Rhode Island's Nursing Workforce." This was part of Shape Phase II, a nursing workforce study. The study was not designed to identify solutions. The objective was to examine 6 central nursing workforce questions in RI: nursing workforce profile (age and care setting), factors influencing the supply of nurses, trends in nursing school enrollments (70% in the workforce graduated from a school in RI), projected demand through 2020, current and future supply, demand, and gaps, and potential solutions or options. The governance was guided by a broad panel of 22 local experts, conducted by international consultants. The methodology consisted of a supply-demand-gap framework, and primary research. (For additional detailed information, please refer to: www.rishape.org.)

Supply included: current supply, trends influencing supply, and projected future supply. Demand included: population demographics, nursing utilization patterns, trends influencing demand, and projected

future demand. Supply-demand imbalance assessed the adequacy of the current and future supply, and potential solutions/options to address the 'gaps.' The data sources included qualitative data (20 in-depth interviews and focus groups), and quantitative data (a survey of 4,000 RI nurses- with a 70% response rate, and data collection from all care settings).

The supply profile (2004) found that there are 20,000 licensed nurses in RI, 72% of whom work in RI as a nurse. 64% of the RNs work full-time, half in acute care settings. Over half of the LPNs work in long term care settings. The workforce is aging (30% of RNs and 50% of LPNs are over 50). 40% of RNs have at least a baccalaureate degree. Full-time RNs work 41 hours per week on average (similar to national figures). Based on the 41 hour work week, there are 12,000 nurse FTEs in RI.

The key supply drivers were: population (an aging workforce and decrease in future supply of up to 10% by 2010, and up to 40% by 2020), work satisfaction (82%- 89% were overall satisfied), compensation (60% feel under-paid, and average salaries are above the national average and slightly below New England), alternative opportunities (1 out of 8 nurses under age 60 plan to leave the profession), and education/job opportunities (future supply is constrained, and there are limited number of seats in nursing school programs).

The current demand for nurses in RI ranges from 12,500- 13,500 FTEs. The hospital RN demand is about 54% of total RNs, and the non-acute/ long-term LPN demand is about 49% of total LPNs. Aging baby boomers will increase demand up to 11% in 2010 over current (2004) levels, and up to 24% in 2020 over current (2004) levels. Select demand drivers are: population served/ demographics (aging baby boomers, increased life expectancy, and changes in migration), epidemiological trends (future increases in demand due to increases in obesity, asthma, Alzheimer's, and potentially others), medical technology (overall impact complicated and unclear), care location (shift from inpatient to outpatient and long term care), and regulation & policy (mandatory staffing ratios and insurance policies).

The overall future gaps are 8% today and up to 55% by 2020. The projected gap for RNs by 2020 is 35%-55% (over 11,000 RN FTEs). For LPNs the projected gap is 45%- 60% by 2020.

The proposed supply side options cost upward of \$100,000,000. They include recruitment strategies, attraction and retention strategies, and limitation of supply side solutions. Solutions must be a combination of supply and demand side options. The proposed demand side options include: workforce

design, location of care, technology & environment design, and preventive care. The proposed next steps for supply side are: increasing nursing school capacity, attract young people to the profession, improve the work environment, align financial incentives with skill and education, and attract out-of state nurses. The demand side solutions are integrated & systemic and require collaborative effort of all stakeholders.

Comments were made that all of the state colleges have been addressing the need to open schools, where the bottleneck occurs. There is a huge problem with faculty shortage. The State generously came forward and approved plans developed by 3 schools. Recruitment efforts have been successful. However, the faculty ratios remain 1:8. 50% of URI graduates leave the state. Also noted was that there had been an erroneous assumption that even a small shortage of nurses would push out salaries. This was found not to be true.

Dr. Meg Richards of Qualidigm presented “Nursing Home & Home Health Satisfaction Measurement Update.” The nursing home resident satisfaction surveys were conducted between April and June 2005. The interviewers received training, and administered the 51 question survey. To date, 3,103 interviews were completed (304 were short-stay patients, and 2,799 were long-stay patients). For a variety of reasons, 121 interviews were not able to be completed, and 484 interviews were attempted and failed. A language barrier was present in 60 interviews. Pilot data was reported to the nursing homes on 9/8/05.

Home Health Satisfaction began in January, created a Subcommittee and two workgroups (RFP and funding), and has met at least monthly since then. An RFP was finalized in April, released in May, and two bids were received in June. In June and July, the proposals were reviewed and scored, and live presentations were given by the two bidders, Fazzi Associates and Press Ganey. In August, the group decided by consensus to recommend Press Ganey to the Steering Committee. In August and September, preliminary negotiations began with Press Ganey, pending final approval of the Steering Committee. If final approval is given by the Steering Committee, the core questionnaire needs to be finalized to incorporate questions on homemaker services, and contracts need to be developed.

The essential differences between Fazzi and Press Ganey are that Fazzi’s specialty is home health care and quality improvement. Fazzi often provides custom work, uses subcontractors, and has a medium turn-around time. Fazzi is small and local. Press Ganey’s specialty is public reporting. They negotiate custom work, do not subcontract, and have rapid turn-around time. They are a large, Mid-western organization. Press Ganey was selected because they have more experience with public reporting, we know of their work from the Rhode Island hospital public reporting, they made efforts to significantly reduce costs. Current Fazzi users did not strongly object to Press Ganey, and the current Press Ganey user strongly objected to Fazzi. The current Fazzi users are not precluded from continuing to use Fazzi, but must use Press Ganey (if confirmed) as the selected vendor to participate in the public reporting program.

The costs include volume based contract fees ranging from \$750- \$2,350, covering the pilot and public phases of the project. In addition, there are survey fees of \$1.60 per mailed survey. The smaller agencies will have a census survey, and the larger agencies will be sampled. The estimated total for two years is \$920 for small agencies and \$3,060 for large agencies. We have yet to identify any cost relief mechanisms through state, federal or grant funding. This is still being pursued.

The anticipated timelines for the pilot are to complete contracting by December 2005, conduct the survey during the first quarter of 2006, disseminate the information to the home health agencies by July, and work on corrections to the pilot through November, 2006. The public report cycle will begin January 2007, ending with a public report in September 2007.

Among the challenges faced in this effort are funding, and using one instrument for diverse patient populations (long-term vs. short-term, skilled care vs. non-skilled, Medicare certified vs. non-Medicare certified).

It was noted in the discussion that the home care agencies have not had a rate increase in 3 years. The expense of this survey, in addition to rising gas prices, presents hardship to agencies, particularly the smaller agencies. Unlike nursing homes that were reimbursed approximately 65% by Medicaid, there is no reimbursement for home health agencies. The question was raised, as the program moves into smaller arenas whether there is a minimum population to consider going forward. It was noted that, ideally, universal participation is the goal.

It was recommended to: (1) move forward with Press Ganey, (2)continue searching for other sources of funding, (3)consider seeking increased Medicaid rates for home health agencies, (4) develop a line of cost effectiveness, and (5) present 3 financial options at the next Steering Committee meeting.

(For electronic copies of the presentations, please email Sue Oberbeck.)

Meeting Adjourned: 4:50 PM

Next Scheduled Meeting: Monday, November 14, 2005

Respectfully Submitted:

Susan A. Oberbeck, MSW, MHA